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Exposing emotional labour experienced by nursing students during their clinical learning experience: A Malawian perspective



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ABSTRACT

Background: Clinical nursing education is a fundamental component in the pre-registration nursing curriculum and literature reflects its challenges.

Aim: The study investigated the clinical learning experience of undergraduate nursing students in Malawi to explore their perceptions of the experience.

Design: This was a hermeneutic phenomenological study.

Setting: The study took place at a University Nursing College in Malawi.

Participants: Participants for the study were purposively selected from among third and fourth year undergraduate nursing students. The sample consisted of 30 participants and their participation was voluntary.

Methods: Conversational interviews were conducted to obtain participants' accounts of their experience and a framework developed by modifying Colaizzi's procedural steps guided the phenomenological analysis. In a hermeneutic phenomenological study, interpretation is critical to the process of understanding the phenomenon being investigated. The findings have been interpreted from a perspective of emotions, utilising emotional labour (Hochschild, 1983) as a conceptual framework which guided the interpretive phase.

Results: The study findings reveal that the clinical learning experience is suffused with emotions and students appear to engage in management of emotions, which is commonly understood as emotional labour. Emotional labour is evident in students' narrative accounts about their caring encounters, death and dying and caring-learning relationships as they interact with clinical nurses and lecturers during their clinical learning experience.

Conclusion: Effective clinical teaching and learning demands the emotional commitment of lecturers. The understanding of emotional labour in all its manifestations will help in the creation of caring clinical learning environments for student nurses in Malawi.

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1. Introduction

This paper presents part findings of a study exploring the clinical learning experience of undergraduate nursing students in Malawi. Clinical nursing education is a fundamental component in the pre-registration nursing curriculum (Chan, 2001). It takes place in what is commonly referred to as the clinical learning environment (CLE) and literature reflects the complexity of learning in such an environment. Lewin (2007) maintains that the educational situation in hospital wards is intrinsically more complex than that

in the School because its primary concern is patient care and not student education. Problems prevalent in the CLE in Malawi add to the complexity of learning in the clinical setting. There is severe shortage of nurses and the vacancy rate is 74% (World Health Organization, 2011). In addition, most hospitals are congested with patients and have inadequate supplies and equipment for providing patient care. These problems negatively impact on both clinical teaching and learning and prompted the conduct of this study. Its aim was to explore the students' perceptions of their clinical learning experience, in view of the problems prevalent in the CLE.

The study did not set out to investigate students' emotions, but in a hermeneutic phenomenological study, interpretation is seen as critical to the process of understanding the phenomenon being investigated (Laverty, 2003). The paper discusses the researchers'

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interpretation of the study findings. Geanellos (1998) asserts that interpretive understanding resides within and emerges from a certain perspective. In this paper, the researchers draw on Hochschild's (1983) concept of emotional labour and interpret the students' narratives from a perspective of emotions. The paper therefore discusses emotional labour within the context of clinical learning. It portrays a unique dimension of emotional labour and this can be attributed to the challenging nature of the CLE in which Malawian nursing students gain their clinical practice experience.

1.1. Conceptualising emotional labour

Emotional labour is a concept which was first defined by Hochschild, an American sociologist (Mann, 2005). In simple terms it refers to emotion management or management of feelings and Hochschild defines it as "the induction or suppression of feelings in order to sustain the outward countenance that produces the proper state of mind in others of being cared for in a convivial safe place" (Hochschild, 1983, p. 7). In her seminal work on flight attendants, Hochschild claims that smiles are part of their work, a part that requires them to coordinate self and feeling so that the work should seem effortless. She further claims that part of the job is also to disguise fatigue and irritation in order to promote passenger contentment. She indicates that such a feat calls for emotional labour. Some similarities can be drawn between flight attendants and nurses in that they are both preoccupied with caring in one way or another, and that negative emotions can significantly affect the care they render. Hochschild clearly portrays this similarity by stating that "most of us have jobs that require handling other people's feelings and our own, and in this case we are all partly flight attendants" (Hochschild, 1983, p.11).

Several nursing authors have been instrumental in defining and portraying the application of emotional labour to nursing. For example, Huynh, Alderson, and Thompson (2008) assert that emotional labour has to do with the emotions and thoughts that nurses feel inwardly but they cannot express them in practice. James (1989) defines it as the labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions. In this paper, emotional labour is defined as the internal regulation or management of emotions which takes place when an individual perceives a mismatch between the inner emotions and the expected emotions to be displayed. This is consistent with Mann (2005) who states that it is the emotional dissonance which leads to emotional labour. Hochschild views emotional labour as being part of a distinctly patterned yet invisible emotional system. She conceptualises it as taking place through surface and deep acting. Surface acting involves consciously changing one's outer appearance so that the inner feelings correspond to the outward appearance, while deep acting involves changing inner feelings so that they become authentic feelings. She asserts that surface acting is associated with feelings of dissonance but this is not experienced with deep acting because of the degree of authenticity achieved. While Hochschild claims that emotional labour occurs through acting, de Raeve (2002) argues that the application of acting to nursing is problematic and she wrote, "I would want to claim that a nurse's impetus towards a deepening of his or her understanding and compassion could have nothing to do with acting, whether 'deep' or otherwise" (de Raeve, 2002 p. 470). She further argues that the nurses' efforts to manage emotions are influenced by a sense of moral concern and should not be viewed as acting. This argument seems quite convincing considering that caring is a moral enterprise.

Fineman (1993) maintains that organisations should be regarded as emotional arenas and emotional labour is therefore an important part of the labour process for both private and public service organisations (Hochschild, 1983). In view of this, it is

argued that emotional labour is essential to both nursing practice and nursing education. Smith (2012) asserts that nurses have to work emotionally on themselves in order to care for patients. Nurses engage in emotional labour in order to maintain a professional demeanour of smiling and compassionate nurses (Bolton, 2000; Smith, 2008). Furthermore, Bolton (2000) states that nurses offer extra emotion work as a gift to patients and in such cases this is motivated by altruism. Bolton (2001) also claims that nurses are multiskilled emotion managers and are able to present themselves in different ways depending on the prevailing emotional climate. Nurses draw on different sets of feeling rules to achieve this. Feeling rules are the key determinants of emotional labour and these are "guidelines for the assessment of fits and misfits between feeling and situation" (Hochschild, 1979, p. 566). Smith (1992) defines feeling rules as moral stances that guide action.

2. Methodology

2.1. Research design

This was a hermeneutic phenomenological study which explored the clinical learning experience of undergraduate nursing students in Malawi. Heidegger (1889–1976) and Gadamer (1900–2002) are the two phenomenologists whose philosophical tenets underpinned the study. The qualitative approach was chosen because it is committed to investigate the social world from the perspective of the people being studied (Bryman, 2004). The social world is the world interpreted and experienced by its members from the 'inside' (Blaikie, 2000). Student nurses are 'insiders' in so far as clinical learning is concerned and their narrative accounts provide the 'insider view.'

Sokolowski (2000) defines phenomenology as the study of human experience and the way phenomena manifest through such experience. Clinical learning is a human experience and this justified the need for a phenomenological inquiry. There are two main approaches to a phenomenological inquiry namely, hermeneutic/interpretive phenomenology and transcendental/descriptive phenomenology. Husserl (1859–1938) developed descriptive phenomenology while Heidegger developed hermeneutic phenomenology. Bracketing was one of Husserl's major concepts, and this implies suspending prior knowledge so that fresh impressions about phenomena can develop without any interference on the interpretive process (LeVasseur, 2003). Fleming, Gaidys, and Robb (2003) argue that it is very difficult, if not impossible to lay aside one's preunderstanding or foreknowledge, which the current researchers concur with, and it is for this reason that descriptive phenomenology was not used in this study.

2.1.1. Application of Heidegger's philosophical tenets to the study

Heidegger is one of the existential phenomenologists and he believed that 'humans' are always caught up in a world into which they find themselves thrown. This led him to develop the notion of 'In-der-welt-sein,' which means 'being-in-the-world' (Moran, 2000). According to Heidegger, phenomenology is directed at understanding 'Dasein,' which is translated as 'the mode of being human' or the situated meaning of a human in the world (Laverty, 2003). This implies that our being is always a 'being-in-the-world,' and therefore our understanding of the world comes from our experiences in the world that we must make sense of (Freeman, 2007). Furthermore, Heidegger claimed that the goal of phenomenology must be to understand 'Dasein' from within the perspective of a lived experience (Moran, 2000). This reflects the need to understand the 'lifeworld' of student nurses on the basis of their lived experience, which constitutes substantially their clinical learning experience.

Heidegger also believed that phenomena manifest themselves in a 'self-concealing manner' (Moran, 2000), implying that phenomena do not manifest themselves fully. His assumption was that the lived experience is veiled and the researcher's responsibility is to unveil the experience through interviewing, reading and writing (Wilson & Hutchinson, 1991). He believed that phenomena cannot simply be described, but rather that phenomenology has to do with the seeking of hidden meanings which can be achieved through interpretation of text. He believed that this manifests the hidden structures of a phenomenon (Cerbone, 2006). Likewise, clinical learning is a veiled experience and the students' narrative accounts would not have fully revealed the nature of their experience. It was for this reason that the narrative accounts of the students who participated in the study were interpreted. This approach revealed the hidden structures that inform the clinical learning experience of Malawian nursing students.

2.1.2. Application of Gadamer's philosophical tenets to the study

Gadamer (1900–2002) is acknowledged as being central to the development of contemporary hermeneutic philosophy (Pascoe, 1996). His main concern was what made understanding possible (Fleming et al., 2003). He believed that Language is the universal medium in which understanding occurs and he wrote, "Human language must be thought of as a special and unique life process since in linguistic communication, 'world' is disclosed" (Gadamer, 2004, p.443). Similarly, Holstein and Gubrium (1997) maintain that meaning is actively and communicatively assembled in the interview encounter. In view of this, conversational interviews were conducted to obtain accounts of students' experience.

Additionally, Gadamer believed that understanding can only be possible in the presence of a historical awareness which he referred to as prejudice or preunderstanding. The concept of prejudice does not carry with it any negative connotations but it is a judgment which is rendered before all the elements that determine a situation have been finally examined (Gadamer et al., 2004). Debesay, Naden, and Slettebo (2008) assert that our prejudices or preunderstanding are necessary conditions for our understanding of the present. Accordingly, knowledge of, and insights into emotional labour constituted the current researchers' preunderstandings, enabling them to understand the clinical learning experience of Malawian nursing students.

Furthermore, Gadamer believed that understanding is always an historical, dialectic and linguistic event and is achieved through what he called 'fusion of horizons.' The concept of horizon refers to "the range of vision that includes everything that can be seen from a particular vantage point" (Gadamer et al., 2004, p. 3001). Turner (2003) points out that the things that are part of our understanding, our view point are our horizons. Understanding involves a critical and reflective process which enables the researcher to create more empowering interpretations (Freeman, 2007). The researcher enters into a dialogue and in this interpretive dialogue, between the text and the interpreter, resides the 'fusions of horizons,' which is a fusion of the text's horizon with that of the interpreter (Hekman, 1986, p. 111). Dialoguing with texts or transcripts of the students' narrative accounts of their clinical learning experience led to a fusion of the students' horizon and that of the researchers. Through this process, findings were put into a perspective that enhanced understanding of clinical learning in Malawi.

2.2. Study setting and sample

The study took place at a University Nursing College in Malawi and the participants were recruited by one of the researchers. Third and fourth year undergraduate nursing students were purposively selected to participate in the study. This sampling method selects

individuals for study participation based on their particular knowledge of a phenomenon, for the purpose of sharing that knowledge (Streubert & Carpenter, 2011) and this was the main reason for selecting senior students as the study population. The sample consisted of 30 participants and their participation was voluntary. The sample was large because in a hermeneutic phenomenological study, 10–25 participants are usually an acceptable sample size (Burns & Grove, 2009). However, a larger sample was obtained in order to attain data saturation.

2.3. Ethical considerations

Ethical review is important in order to ascertain the safety of research participants and in view of this, ethical approval to conduct the study was obtained from the ethics committee for the School of Health in Social Science at the University of Edinburgh. In Malawi ethical approval was obtained from the ethics committee at the College of Medicine (COMREC) and the reference number is P.09/09/828. In addition, permission to conduct the study was obtained from the head of the institution where the study took place. Respect for human dignity is one of the primary ethical principles on which standards of ethical conduct in research are based. This includes the right to self-determination and implies that humans should be treated as autonomous beings capable of controlling their activities (Polit & Beck, 2008). This demanded that prospective study participants should have the right to decide voluntarily to participate in the study without any coercion and their participation was voluntary. Both verbal and written consent were obtained from students who participated in the study prior to data collection. Participants were assured that anonymity and confidentiality would be observed and these were achieved by using designated speaker identifiers or codes.

2.4. Data collection

Conversational interviews were conducted to obtain the participants' accounts of their clinical learning experience. This means that the interviews were conducted in such a way as to initiate a dialogue and not a question and answer response. This is consistent with Gadamer et al. (2004) who believed that language has its true being only in dialogue where human understanding is concerned. According to Gadamer, the aim of the conversation is to allow immersion into the subject matter and this enables the researcher to gain understanding of the phenomena being investigated (Fleming et al., 2003). Each participant had one interview session and the interviews lasted one hour on average. Each session was recorded on an audio tape recorder and transcribed verbatim. Interviews were done until data saturation was achieved.

2.5. Ensuring rigour

Qualitative research is often criticised for lacking scientific rigour, and the most common criticism is that qualitative research is anecdotal, impressionistic, and strongly subject to researcher bias (Koch & Harrington, 1998). Finlay (2003) asserts that objectivity is also hindered because the 'self' is viewed as a potential contaminant because s/he actively constructs the collection and interpretation of data, and contamination can occur during these stages of the research process. Lietz, Langer, and Furman (2006) indicate that rigour within qualitative research involves engaging in efforts that increase the confidence that research findings represent the meanings presented by participants. This enhances the trustworthiness of the findings as they reflect the meanings according to participants' constructions of the phenomena under investigation. Lincoln and Guba (1985) recommend four criteria for promoting trustworthiness of study findings which include credibility,

dependability, confirmability and transferability. Furthermore, Lincoln and Guba (1985) proposed some strategies to enhance credibility of findings and in this study persistent observation and member checking were utilised. Persistent observation helps the researcher to identify salient issues in relation to the phenomena being investigated and to explore them in detail (Lincoln & Guba, 1985). This was possible because one of the researchers conducted the interviews and was able to identify salient issues and to explore them further during subsequent interviews. Member checking is the most crucial technique of establishing credibility of findings and it involved validating the findings with the participants from whom data was collected (Lincoln & Guba 1985). According to Lincoln and Guba (1985) the confirmability audit is the main technique for establishing confirmability of the study. This was achieved through an audit of the researchers' trail of theoretical, philosophical and methodological decisions (Koch, 1996). Clayton and Thorne (2000) assert that a completed reflexive diary provides evidence from which the decision making trail could be audited and a diary was maintained throughout the research process for this purpose. There is evidence that there are close links between dependability and confirmability (Lincoln & Guba, 1985) therefore, the same strategies apply and promote dependability of the study. Additionally, the study findings include excerpts from students' narratives and this is aimed at enhancing the credibility of findings as it portrays that the study findings are representative of the participants' views. Transferability refers to the generalizability of findings to other settings. This has been achieved through the inclusion of sufficient descriptive data for readers to evaluate the applicability to other settings.

2.6. Data analysis

A framework developed through modification of Colaizzi (1978)'s procedural steps guided the phenomenological analysis. The modification was essential because of some observed limitations. Colaizzi's approach does not portray the important role that reflection plays in enabling the researcher to develop meaning of the phenomena being investigated. The method mainly involves extracting phrases or sentences that directly pertain to the investigated phenomena. However, phenomenological analysis goes beyond mere extraction of phrases, the researcher deeply engages with texts through reflection and gains insight of the phenomena being investigated (Richards & Morse, 2007). Additionally, Colaizzi's method does not suggest that all understanding is dependent upon preunderstanding (Fleming et al., 2003), which Gadamer greatly upholds as being significant. Recognising that Gadamer's philosophical tenets underpinned this study; this was considered a major weakness of Colaizzi's method. The modification involved incorporation of some ideas from Fleming et al. (2003) and Diekmann (1992), creating an eclectic framework which guided the analysis.

Data analysis progressed following step by step approach. The interviews were followed by verbatim transcriptions. The next step involved reading and examining each interview text to identify expressions which reflected the fundamental meaning of the text as a whole. Line by line reading was done to extract phrases or sentences that directly pertained to the clinical learning experience and to identify salient issues emerging from the narrative accounts. This was a rigorous and reflective process of going over every word, phrase, sentence and paragraph in the text to elicit the participants' meanings (Hycner, 1985). This enabled the identification of emerging themes. In a hermeneutic phenomenological study, it is a requirement that the researcher interprets the findings to understand the phenomenon being explored. Accordingly, the findings have been interpreted from a perspective of emotions, uti-

lising emotional labour (Hochschild, 1983) as a conceptual framework which guided the interpretive phase.

3. Findings

The presented findings reflect the researchers' interpretation and the themes portray the emotional aspects of the students' clinical learning experience. The findings confirm that clinical learning is an experience suffused with emotions and emotional labour (Hochschild, 1983) is inevitable. Although this study did not set out to investigate students' emotions, what seems to resonate from their narrative accounts is the emotion management or emotional labour which characterise their clinical learning experience. This is consistent with the assertion that language is a signifier of hidden meanings about implicit aspects of emotions (Froggatt, 1998) and that language is 'world disclosing' (Gadamer et al., 2004). The identified themes reveal salient issues within the students' clinical learning encounters from which emotional labour is evident. The students' narrative accounts on provision of care to patients, death and dying and also caring-learning encounters as they interact with clinical nurses and lecturers portray emotional aspects. The study findings are presented based on these themes.

3.1. Emotional labour during caring encounters

The study reveals that during clinical placements sometimes students are left to take charge of the ward, and provide care to patients without the supervision of qualified nurses. Some of the comments which the students made in relation to these issues reflect the emotional labour they engage in as they take care of patients unsupervised. One student said:

When students go on a clinical allocation, nurses take that as a way of covering up the shortage of staff... you would see that they are leaving you alone to do nursing work. And there are times whereby you don't know what you are supposed to do, there is no senior, you are alone as a student and you are 'stuck'.

There is severe nursing shortage in most clinical settings in Malawi leading to excess workload and this is arguably one of the potent factors which cause nursing students to engage in emotional labour during their caring encounters. Students reported of feeling physically fatigued and one student had this to say:

There is really a high workload yah ... You have so many patients ... And then you are just a student, you just have to do whatever the nurses want you to do... So you are forced to do so many things... so the workload is really too much.

Some of the qualified nurses are responsible for assessment of students' clinical competence and this also imposes its own challenges on the students. The following account illustrates this:

When we are in the wards, the nurses think we are there to cover the shortage. They would leave everything on us and when knocking off at five pm, you end up being very tired because you have worked a lot... They would say you are a student you are not supposed to sit down, you are supposed to be doing everything in the ward, and we are the ones who are going to sign your competences. So, you force yourself even if you are tired. So if they just sit (nurses) down, and if you think of the well-being of the patient, you go and do it.

Nursing students acquire some of the professional values such as compassion and empathy during caring encounters and one of the students gave the following account:

Sometimes a guardian (patient's relative) may call you while something is not wrong... but for you just to go to that patient,

that guardian will never forget you. But look at what you did. . . you can't find a rationale how it helped the patient. . . But I have learnt that it has such meaning, a lot of meaning to the people than we expect.

Likewise, another stated:

Different people come into the ward, some of them very poor, some of them very rich and from different cultures. . . But then I have learnt how to have sympathy, not only sympathy and even empathy. Because when we have a patient right in the ward, there is a certain connection between me as a nurse, and the patient regardless of their status.

These findings reveal that the severe nursing shortage and allowing students to take care of patients unsupervised are some of the factors which cause them to engage in emotional labour. Furthermore, the students' language also indicate that developing empathy towards patients also requires emotion management.

3.2. Emotional labour and death and dying

Nursing students in Malawi encounter death of patients early in their clinical experiences and this is also one of the challenges which they experience during caring encounters. The study reveals that death of a patient sometimes cause fear in students and one student had this to say:

In the first place, what I feared most was to see someone dying or see a dead body. . . So one of the objectives then was also to prepare a dead body. I was so afraid to say what am I going to do? Am I going to take part in preparing the dead body? . . . What is going to happen to me when I go back to College?

Similarly, another student said:

Most of the times when it comes to confirming death, I was usually afraid. I was in year two at that time and I was left alone. . . and then came this guardian who asked me to go and see her patient. So I knew that they were calling me to go and confirm death; so I was like this is my first time, what am I going to do?

The study also reveals nursing students being emotionally affected by death of a patient they felt they had a good relationship with. In such cases, death of a patient is perceived as being quite stressful and one of the difficult moments which they experience during clinical placements. One student gave the following account of her experience:

I had a patient who was HIV seropositive. She was not yet on antiretroviral drugs because by then the CD4 count was ok and there was no need to commence the treatment. Now upon being told that she was HIV positive, she became so depressed that she could not eat. . . When she came in the ward she was vomiting. I was in first year of course, I could not know the basis for some of her symptoms, but I was able to provide basic care. . . After three days of nursing interventions, the patient started gasping. . . Oxygen therapy was commenced and we only stayed for ten minutes and the patient asked me, "Can I have your hand?" Then she got hold of my hand and that was the first time seeing someone dying and I was trembling. . . I saw the last breath! To me it was the most depressing moment I ever had. . . I was just looking at her physically she was very fat; now she has died it really affected me.

Similarly, another gave the following account:

I was caring for a patient and the interaction was so good with the patient and the guardians. I did everything. . . up until when this patient died. And when it happened, the guardian rushed

and grabbed me, "sister, that child has died!" So I was just in her hands, I just stood, I had nothing to say, I just touched her again and we just stood there. . . I felt like crying as well, but I know I am a nurse. . . it was a difficult moment.

These findings indicate that death of a patient arouses negative emotions in students, more especially death of a patient where there is a good nurse-patient relationship. However, holding back oneself from crying is an indication of emotion management. This is consistent with [Penson \(1990\)](#) argues against giving in to one's own feelings because it can make one to lose perspective of the supportive role and this is true even in these contemporary times.

3.3. Emotional labour in caring-learning relationships

The key individuals in students' clinical learning include the ward sisters and other qualified nurses, lecturers, the patients and the students themselves. Clinical learning therefore takes place within caring-learning relationships. The nurse-student interaction in the clinical setting is also one of the factors which cause students to engage in emotional labour. Some of the nurses display dismissive attitudes towards students and in some clinical settings the atmosphere is hostile and oppressive. One of the students described it this way:

I had a bad experience in the (*name of unit*) and I went there not a lot of days. . . The moment you do something, they shout at you.

Such encounters lead to absenteeism and non-learning and this is illustrated in the following account.

If the nurses are not friendly, they are not approachable; you cannot learn much in that ward. . . this contributes to students running away from the ward.

The student-lecturer interaction in the clinical setting is also one of the factors which cause nursing students to engage in emotional labour and one student had this to say:

And most of the clinical allocations we don't have much supervision. The lecturers come maybe once a week and maybe once in two weeks, so when they come instead of maybe supervising, it's like they are a threat or a stressor to the students.

Some lecturers employ what students term 'Policing' in their approach to clinical teaching and the following account illustrates this:

Sometimes other clinical supervisors (*lecturers*) may make learning so hard. . . for example; you are doing a procedure on a client. The clinical supervisor would come like policing you. So you are definitely scared, you cannot perform that procedure as it is expected just because you are anxious. . . The policing is being done in the sense that you are doing the procedure and the supervisor comes in, starts asking you questions.

Another student stated:

Sometimes when lecturers come to the ward you become nervous. . . And then maybe you were doing something right, but just because you have seen that person, (*lecturer*) you become nervous. You don't even know what to do. When he asks you, "what are you doing?" you even fail to explain what you are doing. . . The approach is different, some use approaches like they are policing you.

Furthermore, some lecturers have a tendency to shout at students during clinical teaching encounters and one student had this to say:

But there are some lecturers who when they come to the clinical area, they would shout at you while you are at the patient's bed side and say, "we don't do like that! You want to harm the client!" So when clients hear that, they don't trust you anymore. . . . You feel humiliated and you don't like working anymore . . . So those lecturers discouraged me who shouted at me whilst doing a procedure.

Some lecturers became emotional when they find a student performing a procedure wrongly, and this may be one of the factors which cause them to shout at students. One student said:

I feel lecturers sometimes should not be too emotional when you have done something wrong. They should call you somewhere and then discuss the issues to you thoroughly for you to understand.

The study, understandably, reveals that nursing students prefer lecturers who are friendly and approachable. The lecturer should be calm even when a student has made a mistake. The following excerpt illustrates this.

We are youth so they should be youth friendly, not coming as if they are already angry with something else. . . . You just run away! But some lecturers come while smiling; even greeting you, but some lecturers they don't even greet you (*laughter*). So they should also be smiling at us, and they should be youth friendly yah.

These findings portray the attributes which a lecturer should possess to effectively facilitate learning in the clinical setting. The lecturer should demonstrate interest in the student and it is evident that smiling and greeting a student makes a difference. However, this requires emotional labour.

4. Discussion

The findings in this study portray a unique dimension of emotional labour. It is generally accepted that nurses need to engage in emotional labour in order to be seen to care (Smith, 2012). Arguably, the problems and challenges prevalent within the clinical learning environment in Malawi increase the emotional load on nursing students. For example, the study reveals that sometimes students are left unsupervised and they care for patients without the guidance of nurses. There are times when they do not know what to do when a patient develops a problem, a situation which is described as being 'stuck.' The word 'stuck' has negative connotations and this is in common with Froggatt (1998) who revealed in a study that emotional expressions of hospice nurses were presented in negative ways. Being 'stuck' implies that internally the students have fear. However, they may not manifest this outwardly whilst taking charge of the ward. Consistent with Smith (1992), outwardly, the students might appear to be managing, having a countenance which portray that they know what they are doing and are in control. Debatably, such encounters can involve effort and intense energy expenditure to transform the negative emotions into a socially acceptable professional demeanour.

Furthermore, statements like 'you are forced' or 'you force yourself,' which some of the students alluded to indicate some negative emotions which they experience because of the excess workload. Although the students seem to be compelled to overwork, their commitment and emotional engagement are also explicit in that what causes them to act is the concern for the patients' well-being. This is clearly reflected in Section 3.1 and portrays some altruistic attitudes which engender such a degree of student involvement. McAllister and McKinnon (2009) state that caring for others involves a high degree of self-giving and that in this endeavour the self can also suffer. This however reflects emotional labour

among nursing students because whilst they suffer inwardly, they may not show this to the patients, but may attend to them with smiling faces. Henderson (2001) claims that nurses' emotional commitment to patients goes beyond what one may feel personally and that this contributes to the quality of nursing care.

In Malawi, patients' relatives are normally present in the wards and they are the ones who sometimes alert the nurses of any problems arising. Depending on the nature of their relative's illness, sometimes they are equally apprehensive and may seem to be calling on the nurses 'unnecessarily.' This is an issue which causes some of the nurses to shout at patients and their relatives but the student learnt something important. The statement, "you can't actually find a rationale how it helped the patient," which one student made referring to the fact that she could not understand how her interventions helped the patient confirms the assertion that caring has to do with the 'little things' we do (Pearcey, 2010; Smith, 2012). Another student mentioned that she learnt to get connected to patients regardless of their poverty and to be empathetic. These findings support the assertion by Smith and Gray (2001) that emotional labour creates an almost invisible bond that the nurse develops with the patient. Larson and Yao (2005) indicate that empathy involves both internal and external emotion management. They define empathy as "a psychological process that encompasses a collection of affective, cognitive and behavioral mechanisms and outcomes in reaction to observed experiences of another" (Larson & E.B., 2005, p.1102).

The study reveals emotional labour among students engendered by the nature of the student-lecturer interaction in the clinical setting. There is evidence that there is minimal clinical supervision which hinders the development of effective student-lecturer relationships. Some lecturers shout at students and some employ what students term 'Policing' in their approach to clinical teaching. Such interactions arouse negative emotions and students reported of actually 'running away' from such lecturers. This is a distancing or detachment strategy which students employ when handled in an impersonal way. It is argued that the gloomy countenance which some lecturers manifest indicate failure to suppress or induce feelings accordingly and this confirms that student-lecturer interactions in the clinical setting can be associated with heightened emotions.

Students reported of shame and humiliation as a result of being shouted at by lecturers in the presence of patients. This is consistent with Bond (2009) who recognises that shaming practices do occur in nursing education and that they seriously impede effective teaching and learning. Potentially shaming practices in nursing education include: correcting a student in front of patients, staff or peers; ignoring a student; becoming impatient with a student; displaying verbal or non-verbal contempt in response to student's lack of knowledge or skill; or refusing to provide help to a student (Bond, 2009, p.133). The study reveals that students also resent lecturers who embarrass them and they employ distancing strategies to protect their emotions. The presence of a lecturer in the clinical setting causes considerable stress among nursing students and arouses negative emotions. This results in students failing to perform nursing procedures correctly and even failing to answer questions. Literature indicates that emotions and thought are interconnected (Weiss, 2000). Therefore, the failure by the students to answer questions proves that the negative emotions which the lecturer-student interaction arouses interfere with their cognitive abilities.

Smith (1992) indicates that handling students in a way that demean their self-worth causes them temporarily to lose both their technical and emotional confidence to care for patients. This explains the reason for the apathy which students develop following such encounters. For example, one of the students mentioned of not wanting to work after being shouted at by a lecturer. It is

also argued that the tendency by some lecturers to shout at students is a consequence of unmanaged emotions and this illustrates the need for them to engage in emotional labour for them to effectively facilitate clinical learning. Nursing students prefer lecturers who are calm even when they have made a mistake. They prefer student–lecturer interactions which maintain their self-worth. Midgley (2006) asserts that the clinical field is where students learn to care and it is important that they feel valued and have a feeling of self-worth. Lecturers should demonstrate interest in students and approach them with smiling and friendly faces. This enables them to be calm and relaxed and illustrates that in facilitating students' learning in the clinical setting; it is also the 'little things' that matter. Emotional labour is vital if the student–lecturer interaction in the clinical area will lead to meaningful learning encounters. To this end, Smith and Gray (2001) assert that emotional labour plays a key role in the creation of caring clinical learning contexts.

4.1. Limitations of the study

The main limitation of this study is that data was collected from one University Nursing College in Malawi, such that the findings cannot be generalised. However, Lincoln and Guba (1985) argue that generalisation of findings from naturalistic studies is associated with transferability and relevance rather than reductionist concerns such as sample size. Therefore, these findings provide significant insights into the clinical learning experience for student nurses in Malawi and it is argued that the findings have implications to other countries with similar educational practices.

The fact that the study did not explore students' emotions and yet the findings are interpreted from such a perspective also poses a limitation of the study. However, as already mentioned, this is a requirement for a hermeneutic phenomenological study.

4.2. Recommendations

The study explored the clinical learning experience of undergraduate nursing students in Malawi and the findings have been interpreted from a perspective of emotions. The paper contributes to literature on emotional labour in nursing. There is a paucity of literature on emotional labour in nursing from an African perspective. The implications for nursing education and practice are outlined below:

- The study reveals that clinical learning is an experience suffused with emotions and this is consistent with the assertion that health care work is, by its nature, an area of heightened emotions (Hunter & Smith, 2007). Therefore, it is argued that emotional labour is inevitable and essential for both nursing education and practice. Sylwester (2000) indicates that understanding the importance of emotions and feelings is crucial to effective teaching and learning. Additionally, Day (2004) indicates that good teachers invest large amounts of their substantive emotional selves in pursuing their work with students, and as this study suggests, what is being called for is the emotional commitment of lecturers so that how they respond and interact during clinical teaching sessions can make a difference in the lives of students.
- Inclusion of emotional labour within both nursing education and practice in Malawi is recommended. It will enable student nurses, clinical nurses and lecturers learn to manage their emotions during clinical teaching and learning encounters. This will help in the creation of positive clinical learning environments. To this end, Fredrickson (2003) asserts that organisational members should consider cultivating positive emotions in themselves and others. This promotes individual and organiza-

tional transformation and optimal functioning. Furthermore, emotional labour will enable clinical nurses, student nurses and lecturers to manifest a professional demeanour which conveys care and compassion to patients.

- Various approaches are proposed in order to introduce the concept of emotional labour to nursing education. Freshwater and Stickley (2004) advocates for incorporation of emotions into the nursing curriculum. They contend that "education that ignores the value and the development of emotions is one that denies the very heart of the art of nursing" (Freshwater & Stickley, 2004, p.93). This would enhance the development of emotional intelligence among nursing graduates. In addition, Christiansen and Jensen (2008) identified in a study that role playing followed by peer feedback and group discussions are effective in enabling students to develop emotional learning. This is a teaching strategy which could be utilised in order to produce emotionally competent nursing graduates.
- At practice level, Smith (2012) indicates that compassionate, committed and emotionally sensitive leadership is required to have compassionate and smiling nurses as this is a gesture of care for those who care. Huynh et al. (2008) recommend that training workshops should be conducted for staff and McQueen (2004) suggests that the training should focus on self-awareness, self-regulation and social skills. Additionally, Mazhindu (2003) states that nursing practice cannot dissociate itself from the emotional dimension and she recommends that reflection on practice is the key to opening and exploring the emotional dimensional of caring.

5. Conclusion

Clinical learning is an experience suffused with emotions and this is mainly because of the problems and challenges prevalent in the clinical learning environment in Malawi. The severe nursing shortage, student–lecturer interaction in the clinical setting and dismissive attitudes which some of the nurses display are some of the factors which cause nursing students to experience heightened emotions during their caring–learning encounters making emotional labour inevitable. There is evidence that unmanaged emotions hinder students' clinical learning. It is therefore argued that effective clinical teaching and learning demands the emotional commitment of lecturers. The understanding of emotional labour in all its manifestations will help in the creation of caring clinical learning environments for student nurses in Malawi.

Conflict of interest

We have no conflict of interest to declare.

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